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Legal Pork in the Medicare Bill

ANTITRUST AND MEDICAL MALPRACTICE DEALS SELL OUT CONSUMERS

BY JOHN CONYERS JR.

The Republican Medicare bill, adopted last week by the House of Representatives, was bought and paid for through a series of back-room legal concessions granted to powerful health care special interest groups, most notably the American Medical Association. Included in the grab bag of legal concessions were several significant new loopholes and exemptions to the nation's antitrust and medical malpractice laws. Although those laws originally were designed to safeguard consumer welfare, the Republican bill would alter them in a completely one-sided manner to benefit the AMA and other health care interests at the expense of the nation's consumers.

Moreover, these provisions are so important to the health care industry that they have been drafted to supersede state as well as federal law, even though such an approach directly contravenes the Republican's usual "devolution" rhetoric. Apparently, states can be permitted to handle welfare and Medicaid issues, but cannot be trusted by Congress to protect their citizens against price-gouging and medical negligence.

Equally disturbing is the procedures through which these issues were considered. Not a single hearing has been held on antitrust or medical malpractice issues in the House this Congress. When the Medicare bill was approved by the House Ways and Means Committee, Chairman Bill Archer (R-Texas) cut off debate on the antitrust and medical malpractice issues by indicating that they would be resolved by the committee of jurisdiction—the House Judiciary Committee. Yet Speaker Newt Gingrich (R-Ga.) discharged the Judiciary Committee without granting us any time to consider these issues. And when the bill was considered by the full House last week, Democrats again were denied an opportunity to debate the antitrust and malpractice issues. Further, by folding these provisions into their budget reconciliation plan, the Republicans hope to use special procedural rules to cut off debate in the Senate as well.

UNNEEDED EXEMPTION

The two antitrust provisions included in the bill would:

- Create a new antitrust exemption for so-called medical self-regulatory entities.
- Weaken the application of the antitrust laws to groups of doctors who band together to fix prices.

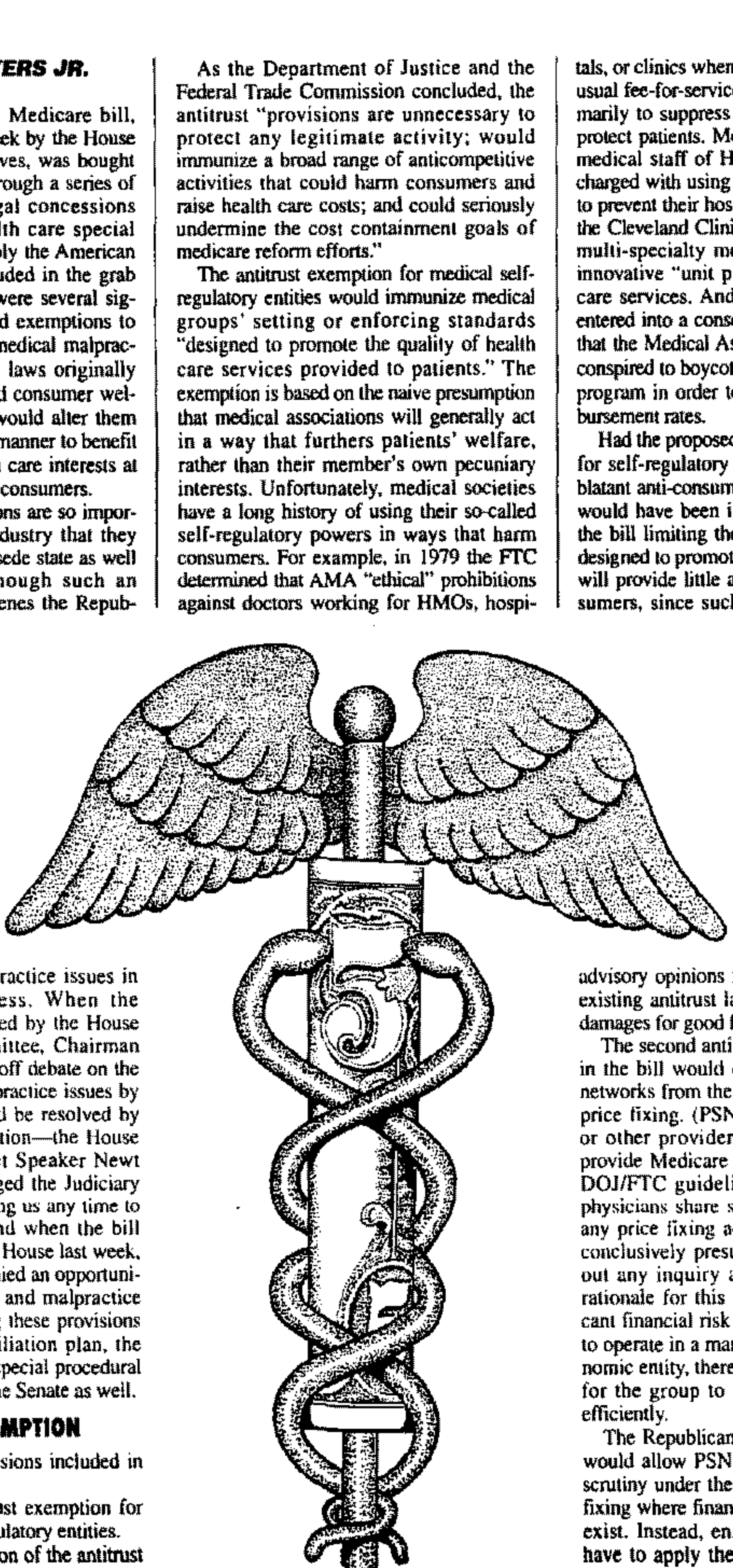
As the Department of Justice and the Federal Trade Commission concluded, the antitrust "provisions are unnecessary to protect any legitimate activity; would immunize a broad range of anticompetitive activities that could harm consumers and raise health care costs; and could seriously undermine the cost containment goals of medicare reform efforts."

The antitrust exemption for medical self-regulatory entities would immunize medical groups' setting or enforcing standards "designed to promote the quality of health care services provided to patients." The exemption is based on the naive presumption that medical associations will generally act in a way that furthers patients' welfare, rather than their member's own pecuniary interests. Unfortunately, medical societies have a long history of using their so-called self-regulatory powers in ways that harm consumers. For example, in 1979 the FTC determined that AMA "ethical" prohibitions against doctors working for HMOs, hospitals, or clinics when fees were lower than the usual fee-for-service fees were designed primarily to suppress competition, rather than protect patients. More recently, in 1991, the medical staff of Holy Cross Hospital was charged with using the credentialing process to prevent their hospital from affiliating with the Cleveland Clinic, a nationally renowned multi-specialty medical group that offers innovative "unit pricing" for many health care services. And just last July, the FTC entered into a consent order settling charges that the Medical Association of Puerto Rico conspired to boycott a government insurance program in order to increase medical reimbursement rates.

Had the proposed new antitrust exemption for self-regulatory activities been in place, blatant anti-consumer conduct of this nature would have been immunized. Language in the bill limiting the exemption to instances designed to promote "quality of health care" will provide little actual protection for consumers, since such justifications are used routinely by groups seeking to reduce output and raise prices for their services. Current law already provides more than adequate protection for legitimate self-regulatory activity, as a result of special health care enforcement guidelines issued by the Justice Department and the FTC in 1993 and 1994, numerous advisory opinions from these agencies, and existing antitrust law limitations on private damages for good faith "peer reviews."

The second antitrust provision contained in the bill would exempt provider service networks from the usual per se rule against price fixing. (PSNs are groups of doctors or other providers that band together to provide Medicare services.) Under current DOJ/FTC guidelines, unless a group of physicians share substantial financial risk, any price fixing activity they engage in is conclusively presumed to be illegal without any inquiry as to harm caused. The rationale for this guideline is that significant financial risk sharing leads physicians to operate in a manner akin to a single economic entity, thereby fostering an incentive for the group to provide health services efficiently.

The Republican Medicare bill, however, would allow PSNs to set prices and avoid scrutiny under the per se rule against price fixing where financial risk sharing does not exist. Instead, enforcement agencies will have to apply the far more elaborate and



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Safeguards Traded for Support

The sacrifice of antitrust, malpractice, and other legal safeguards in the Republican Medicare bill sets a most dangerous legislative precedent.

costly "rule of reason" analysis in order to strike down anti-competitive price fixing. The bill also pre-empts state law enforcement authorities from reviewing PSN price-fixing activity under the per se rule.

The non-partisan Physician Payment Review Commission—established by Congress to provide advice and recommendations regarding physician payments under Medicare—concluded that "current laws and enforcement policies have not deterred the formation of PSNs when they assume risk . . . [and] found no compelling reasons for creating exemptions from the antitrust laws for such networks." As *The New York Times* recently editorialized, easing antitrust rules for PSNs would "invite doctors to engage in blatantly anti-competitive behavior [and] allow doctors who have no intention of going into business together to conspire among themselves to impose high fees and needlessly expensive treatment practices on health plans using their services."

LIABILITY LOOPHOLES

The Republican Medicare bill also includes the most extreme set of medical malpractice and health care product liability provisions ever considered by Congress. The Justice Department has written that under this bill, "the very purpose of the malpractice liability system—to fairly compensate injured victims and to deter future misconduct—would be severely compromised." Indeed, protecting doctors against their own misconduct seems particularly inappropriate in the context of this bill, which dangerously reduces the quality of medical care by forcing seniors into managed care and by deregulating nursing homes and medical laboratories.

Among other things, the medical malpractice language in the bill would:

- Prohibit bringing any health care liability action more than two years after an injury is discovered or five years after the negligent conduct that caused the injury first occurred.
- Set an absolute limit of $250,000—with no adjustment for future inflation—for noneconomic damages (such as pain and suffering) as well as eliminate the doctrine of joint and several liability for noneconomic damages.
- With respect to punitive damages, cap awards at the greater of $250,000 or three times economic damages; limit the state law standard for the award of punitive damages to intentional or consciously indifferent conduct; allow a bifurcated proceeding to determine issues relating to punitive damages; and completely ban punitive damages in the case of drugs or other devices that have been approved by the Food and Drug Administration or any other drug "generally recognized as safe and effective" pursuant to FDA-established conditions.
- Grant wrongdoers the option of paying damage awards in excess of $50,000 on a periodic basis.
- Permit defendants to introduce evidence of "collateral source" payments that may be received by the victim and prohibit insurers from recovering such damages by way of subrogation.

The one-sided nature of these proposals is highlighted by the fact that although the bill allows states to enact more restrictive caps and damage limitations, they are not permitted to grant victims any greater legal rights. The bill also wipes out any state-sponsored alternative dispute resolution mechanism which does not completely conform to these limitations. The latter proposal is particularly counterproductive because it will discourage state experiments to reduce litigation costs.

It is not difficult to envision the inequities these radical medical malpractice concessions could wreak on innocent victims. For example, the proposed new federal statute of limitations takes no account of the fact that many injuries caused by medical malpractice or faulty drugs often take years to manifest themselves. Thus, under the bill, a patient who is negligently inflicted with HIV-infected blood and develops AIDS six years later would be barred from filing a medical malpractice or product liability claim.

Capping noneconomic damages at $250,000 unfairly penalizes a small number of the most vulnerable members of our society. This says to the American people that Congress does not care if you are permanently disfigured or crippled, if you are forced to bear excruciating pain for the rest of your life, or if you lose a spouse or child as a result of medical negligence. Such damage caps would also unfairly create two classes of defendants. For example, if a patient is paralyzed by a surgeon's negligence at the same time a pedestrian is paralyzed after being struck by a speeding car, the malpractice victim could only recover $250,000 in noneconomic damages, but the same limitation would not apply to the pedestrian. Further, by eliminating joint and several liability for noneconomic damages, the legislation will allow wrongdoers to profit at the expense of innocent victims, rather than forcing tortfeasors to allocate liability among themselves, as has traditionally been the case under state law. And since women, minorities, and the poor generally earn less wages, the new limits on noneconomic damages would have a disproportionately negative impact on these groups.

Arbitrary caps on punitive damages will serve only to provide unjustified windfalls to the few tortfeasors responsible for blatant and wanton medical misconduct. (In fact, studies have shown that only 270 medical malpractice punitive awards were awarded in the United States in the 30 years between 1963 and 1993.) The proposed new federal evidentiary and substantive standard for establishing punitive damages will completely insulate grossly negligent conduct and come close to criminalizing tort law. Permitting defendants to bifurcate proceedings concerning the award of punitive damages will lead to far more costly and time-consuming proceedings, again working to the disadvantage of injured victims. And banning punitive damages for FDA-approved products would have a disproportionate impact on women, since they make up the largest class of victims of medical products. We need to look no further than the Dalkon Shield and Cooper 7-IUD cases to see the potential adverse impact that such a provision could have on female victims.

The periodic payment provisions are also written solely from the wrongdoer's perspective. It is one thing to give defendants the opportunity to pay awards on a periodic basis if they relate to future economic damages to be realized over time, such as lost wages. But why should the provision also apply to noneconomic losses, like the loss of a limb, that are realized all at once? Also, in contrast to many state law periodic payment provisions, the Republican bill does not seek to protect the victim from the risk of nonpayment resulting from future insolvency by the wrongdoer or to specify that future payments should be increased to account for inflation or to reflect changed circumstances.

The Republican-proposed changes to longstanding state doctrines concerning collateral source and subrogation are also poorly conceived. In most states, a victim is able to obtain compensation for the full amount of damages incurred, and his or her health insurance provider is able to seek subrogation in respect of its own payments to the victim. This ensures that the true cost of damages lies with the wrongdoer while eliminating the possibility of a double recovery by the victim. The Republican Medicare bill, however, would turn this system on its head by allowing tortfeasors to introduce evidence that the victim may be entitled to obtain compensation from his or her insurer while denying insurers the right to recover any such payments through subrogation. These provisions are designed to persuade juries that damage awards should be reduced by any possible insurance proceeds, lest they permit a double recovery by the victim. By denying insurers the right to subrogate, however, the bill will have the effect of shifting costs from negligent doctors to the health insurance system in general and taxpayers in particular. The result will be increased health care premiums paid by workers and businesses.

MYRIAD AMBIGUITIES

Aside from the obvious equitable concerns raised by these egregious provisions, the bill also raises a veritable hornet's nest of complex legal issues. In the state law context, various damage caps have been held to violate state constitutional guarantees relating to equal protection, due process, and rights of trial by jury and access to the courts; and these very same concerns are likely to be present at the federal level. In addition, the legislation will be subject to a myriad of possible ambiguities. For example, is a particular form of damage economic or noneconomic? How are we to treat a provision of state law that is more stringent in some respects than the proposed federal standard, yet more lenient in other respects? Will such issues require a separate fact-finding determination before the trial begins? And what will we do when the inevitable conflicts ensue—not only within the federal courts and state courts, but between federal and state courts?

These new restrictions on victims' legal rights are being proposed even though the bulk of quantitative evidence contradicts the notion that malpractice limitations result in significant savings to most health care providers. Studies have found that awards to malpractice victims who file suit and succeed are relatively small as a general matter, and that even the total elimination of malpractice costs would have only a negligible impact on overall health care costs. Both the Department of Health and Human Services and the Congressional Budget Office have found that the total amount of all malpractice liability premiums paid in the United States represents less than 1 percent of health care costs. Even factoring in the costs of so-called defensive medicine will not result in any significant additional savings, according to both the CBO and the Congressional Office of Technology Assessment.

OUT OF BALANCE

Although the Republican's Medicare proposal is part of the budget reconciliation process, the antitrust and medical malpractice provisions included in it will do nothing to help balance the budget. If anything, these provisions are far more likely to place increased financial burdens on the U.S. Treasury by minimizing competitive forces and shifting costs from medical providers to patients and their health insurers—most notably, the Medicare trust fund. Moreover, since the antitrust and medical malpractice provisions are not limited to situations involving Medicare, they will have an adverse impact on the cost and quality of health care realized by all health care consumers.

We need to ask whether we are willing to sacrifice important antitrust, malpractice and other legal safeguards and usurp traditional state prerogatives in order to prop up the controversial medicare legislation. In my view these ill-conceived bits of "legal pork" set a most dangerous legislative precedent. If Congress adopts these provisions, it will be sending the special interests a message that any objections they may have to controversial legislation can be overcome by unrelated legal concessions. And once we begin the process of opening up legal protections relating to antitrust, tort and other laws, it will be difficult to prevent other groups from using these same exemptions to justify even more radical changes.

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